


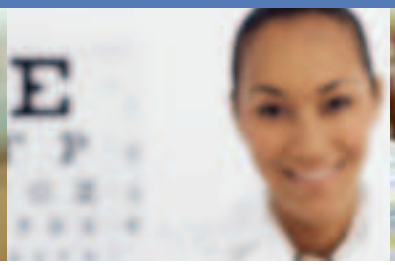


Maximize your benefits. Minimize your costs.

Now you can stretch your income, reduce costs and pay less in taxes. How? By using your Flexible Spending Account (FSA). A valuable benefit provided by your employer, your FSA allows you to use your pretax dollars to pay for health care and dependent care expenses.

Reasons to SAVE NOW with a Flexible Spending Account:

You can save up to 30% on eligible expenses by using tax-free money.

You can use money from your FSA for over-the-counter drugs.

Money is conveniently deducted from your paycheck.

If you are re-enrolling or enrolling for the first time, please take a moment to read the information in this enrollment kit. It is very important to review and estimate your expenses each year before you make your election. After your account is established, you may easily access your confirmation statement and claim form by going to www.ceridian-benefits.com and logging into your account. For first-time users, your password/pin is the last four numbers of your SSN reversed. Select your plan choice from the dropdown menu and click go (if presented).

If you need more information or have questions about FSAs and your options, call 800-586-5120 between 8:00 a.m. and 8:00 p.m. Eastern Time, to speak with a customer service representative.

How Does a Flexible Spending Account Work?

A Flexible Spending Account (FSA) is an employer-sponsored plan that lets you deduct dollars from your paycheck and put them into a special account that's protected from taxes. The money in an FSA account can be used for eligible health care and/or dependent care expenses incurred by you, your spouse and your dependents. FSA accounts are exempt from federal taxes, Social Security (FICA) taxes and, in most cases, state income taxes. Depending on your tax bracket, you may save up to 30% or more in taxes.

Managed human resource solutions that maximize the value of people

CERIDIAN freedom

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Milwaukee County

1. Determine Your Expenses

First you must estimate the amount of health care and dependent care expenses you think you will experience during the plan year. To estimate your expenses, you can use the enclosed FSA Worksheet or use the online FSA calculator at www.ceridian.com/myceridian/fsacalculator.

If you are not sure how to estimate your health or dependent care expenses review your check book and credit card statements from last year and add up your health and/or dependent care costs. This will give you a very good starting point to decide what you will contribute to the FSA next year.

For your current Plan Year 1/1/2007 to 12/31/2007

Annual Amount You May Contribute	Minimum	Maximum
Health Care Flexible Spending Account	**$0.00**	**$3,000.00**
Dependent Care Flexible Spending Account (married filing jointly)	**$0.00**	**$5,000.00**
Dependent Care Flexible Spending Account (married filing individually)	**$0.00**	**$2,500.00**

2. Enroll

Complete the enrollment and sign up for your FSA during open enrollment from 11/01/2006 to 12/01/2006.

a. Web enrollment. Go to www.benefitenroll.com.
   User ID: Enter your Participant ID
   Password: Enter your Participant ID

b. Telephone Enrollment:
   Dial 1-800-586-5120, then follow the instructions.
   Enter your Participant ID as the User ID and enter the same Participant ID as the password.

3. Contribute

At the beginning of this plan year, the annual amount you elected is deducted from each paycheck in equal amounts 24 times throughout the year.

4. Submit for Reimbursement

As you have eligible expenses throughout the year, you submit claim forms for reimbursement from your account. Reimbursements will be made to you from the FSA on a weekly basis.

Eligible claims must be incurred during the plan year. You have 90 days after the last day of the plan year to submit your claims for reimbursement.

You have 90 days following your termination from the plan to submit claims incurred while you were participating.

Important: Calculate your annual FSA contribution wisely. According to IRS guidelines, any money in your FSA that you do not use for eligible expenses incurred during the plan year will be forfeited.

Changing your Election after the Enrollment Period

You can only change your FSA election if you experience a qualified change in status. For more information on qualified change in status, review your FSA Summary Plan Description.

make every benefit count.

Health Care FSA Overview

Enroll in this plan to reduce your out-of-pocket Health Care expenses.

The Health Care FSA helps you save money on your out-of-pocket health care expenses.

By using an FSA, you pay for these expenses with pretax dollars. You save a percentage of each dollar you spend on eligible medical, dental and vision services that are not fully covered or are ineligible for payment under your health care plan.

Whose expenses are eligible?
You may be reimbursed for medical expenses incurred by you, your spouse, your tax dependents, and certain others. For a complete description of whose expenses you should consider, go to www.myceridian.com/105.

Eligible health care expenses may include:

- Health care plan deductibles
- Co-payments
- Amounts over the maximum your plan pays
- Other expenses not covered by your health plan

Out-of-pocket expenses are eligible for reimbursement whether or not they are insured through your company. But you must enroll in the Health Care FSA to take advantage of the tax savings, and the expenses must be incurred while you are participating in the FSA.

Insurance premiums and expenses paid by your health care plan are not eligible for reimbursement under the Health Care FSA. Also, you cannot receive FSA reimbursement for a health care expense if you also itemize the expense as a deduction on your tax returns.

For additional information about expenses that may be considered eligible, please refer to the separate Sample Health Care Expenses Eligibility list. All submitted expenses are reviewed according to Internal Revenue Code Section 125.

Sample Health Care Expense Eligibility

Important Reminder

For each expense, you must submit documentation from the provider or a third party that includes the following:

- Date
- Amount
- Provider
- Type of service

Some expenses may require additional documentation to establish eligibility, such as a physician's statement that a certain expense will treat your existing medical condition.

Equipment

Eligible:

- Diabetic supplies including monitoring system, insulin pump, glucose kit, test strips, lancets
- Blood pressure monitor kits
- Condoms
- Denture supplies
- Female contraceptives and spermicidal products
- Incontinence supplies
- Ovulation and pregnancy tests
- Crutches
- Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition

Ineligible:

- Maternity clothing
- Toilet paper and tissues
- Diapers
- Feminine products including sanitary napkins, tampons, pads

Assistance for the Disabled

Eligible:

- Braille books and magazines in excess of cost of regular editions
- Cost of note-taker for a deaf child in school
- Household visual alert system for hearing impaired
- Walkers, crutches, canes
- Wheelchair and/or including cost of operating/maintaining
- Artificial limbs
- Guide dog or other animal for visually or hearing impaired (includes purchase,training, and care)
- Excess costs of specifically equipping automobile for a disabled person over the costs of ordinary automobile; device for lifting a disabled person into an automobile

Drugs

Eligible:

- Prescription Drugs
- Over-the-counter drugs including allergy, cold relief,diabetic treatment (insulin), pain relievers, smoking cessation,antacid, acid reducers, stomach remedies,topical products (not cosmetics)

Ineligible:

- Drugs for cosmetic purposes
- Toiletries including shampoo, soap, shaving cream, deodorant, toothpaste
- Drugs that are merely beneficial for general health (e.g., multi-vitamins)

Procedures/Treatments

Eligible:

- Anesthesiologist
- Surgery
- Hospital services
- Weight loss programs prescribed to treat a medical condition (e.g., obesity)
- Smoking cessation programs
- Treatment for alcoholism or drug dependency
- Acupuncture
- Infertility Treatment
- Speech therapy
- Physical therapy
- Occupational therapy
- Obstetrical and gynecological procedures
- Dermatological procedures
- Chiropractors and osteopaths
- Sterilization and reversed sterilization
- Nursing services for care of a specific medical ailment
- Cosmetic surgery/procedure that treats a deformity, caused by an accident or trauma, disease, or an abnormality at birth

Ineligible:

- Physical treatments unrelated to specific health problem (e.g., massage for general well-being)
- Any illegal treatment
- Cosmetic surgery/procedures (including anesthesia) that improves patient's appearance but does not meaningfully promote the proper function of the body or prevent/treat an illness/disease

Vision/Hearing

Eligible:

- Hearing aids, batteries for operation of hearing aids, hearing aid repairs
- Optometrist or ophthalmologist fees
- Eyeglasses
- Contact lenses and cleaning solutions
- Corrective eye surgery including radial keratotomy

Ineligible:

- Lens replacement insurance
- Warranties
- Protection plans
- Coating/tints that do not treat a medical condition

Dental

Eligible:

- Dental care
- Artificial teeth/dentures
- Braces, orthodontic services

Ineligible:

- Teeth bleaching
- Tooth bonding that is not medically necessary

Psychiatric Care

Eligible:

- Services of psychotherapists, psychiatrists, and psychologists
- Legal fees directly related to commitment of mentally ill person

Ineligible:

- Psychoanalysis undertaken to satisfy curriculum requirements for a psychoanalysis degree
- Marriage counseling

Insurance

Eligible:

- Deductibles and co-payments for health care plans (e.g., medical, dental, vision)
- Coinsurance (only the percentage of charges not paid by your health care plan)
- Amounts over usual and customary limits

Ineligible:

- All premiums/contributions for insurance coverage (including health insurance, long-term care, loss of income and loss of life)
- Expenses paid by your health care plan

Diagnostic/Preventative

Eligible:

- Routine/preventive physicals
- X-ray
- Vaccinations/Immunizations
- Flu shots

Ineligible:

- Umbilical cord storage

Miscellaneous Charges

Eligible:

- Shipping, handling, delivery charges, and sales tax for eligible expenses
- Expenses connected with donating an organ
- Lodging expenses (not provided in a hospital or similar institution) not to exceed $50 per night per individual while away from home if the lodging is primarily for and essential to medical care provided by a doctor
- Transportation expenses primarily for and essential to, medical care including mileage, bus, taxi, train/plane fares, ambulance services, parking fees and tolls
- Social security tax paid with respect to wages of a qualified nurse's service

Ineligible:

- Payments for child care (eligible under the Dependent Care FSA)
- Diaper service
- Distilled water purchased to avoid drinking fluoridated city water supply
- Installation of power steering inan automobile
- Pajamas purchased to wear in hospital
- Mobile telephone used for personal phone calls as well as calls to physician
- Payments for services which are not medical in nature
- Domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a nonmedical nature
- Nursemaid or practical nurses who render general care for healthy infants

Dependent Care FSA Overview

Enroll in this plan to reduce your out-of-pocket Dependent Care expenses.

The Dependent Care FSA helps you save money on your out-of-pocket health care expenses.

The Dependent Care Flexible Spending Account (FSA) helps you pay for child care services which make it possible for you and your spouse (if applicable) to work. Under certain circumstances it also may be used to help pay for the care of elderly parents, or a disabled spouse or dependent. To be eligible, you must be at work during the time your eligible dependent receives care.

You must meet one of the following eligibility criteria:

- You are unmarried
- Your spouse works
- Your spouse is a full-time student
- Your spouse is seeking work
- Your spouse is disabled (incapable of self-care)
- You are divorced or legally separated and have custody of your child.

Whose expenses are eligible?

You may be reimbursed for childcare for your child under age 13, who lives with you, and who is also your tax dependent. Disabled spouses, and children and others older than 13 may also satisfy the requirements in certain situations; for details go to www.myceridian.com/129.

Expenses may be reimbursed for services provided:

- Inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes or one of your children under the age of 19
- In a dependent care center or a child care center. (If the center cares for more than six children, it must comply with all applicable state and local regulations)
- By a housekeeper whose services include, in part, providing care for a qualifying individual
- Through child or adult day care; through nursery, preschool, after-school, or summer day camp programs. Taxes you pay on wages for eligible dependent care can also be reimbursed.
- By a provider who doesn't intend to claim the income as earnings. Provider's Social Security or Tax ID number and payment/services details must be included with your federal income tax return on Form 2441, and as a result, your provider may have to pay taxes on that income.

Ineligible expenses:

Dependent care for a child 13 or over, overnight camp, baby-sitting that is not work-related, schooling in kindergarten and higher grades, long-term care services. All submitted expenses are reviewed for eligibility according to Internal Revenue Code Sections 125 and 129.

FSA Health and Dependent Care Worksheet

Use this worksheet to help determine your health care and dependent care annual contribution for the upcoming plan year. If you would like to perform your calculations online, you may access the FSA Calculator at www.ceridian.com/myceridian/fsacalculator. You may want to review your health and dependent care expenses in your check book and/or credit card statements from last year to help you decide how much to set aside in your FSA next year.

Health Care FSA

To determine your expenses, review health care expenses from last year and consider any anticipated new health care expenses for you, your spouse and your dependents.

Annual Health Care Expenses

Deductibles $_____
Medical, dental, vision

Co-payments/co-insurance $_____
The amount not paid by your health plan coverage

Amounts paid over plan limits
Over reasonable and customary allowance $_____
Over psychiatric limits $_____

Expenses not covered by insurance
Over-the-counter drugs $_____

Vision care
(glasses, contacts, solution, exams, etc.) $_____

Dental care
(cleanings, orthodontics, crowns, etc.) $_____
Treatment/therapies $_____
Medical equipment $_____

Other anticipated health care expenses
_____ $_____
_____ $_____
_____ $_____

Total Estimated Annual Health Care Contribution

Total $_____

Dependent Care FSA

To determine your expenses, enter in the estimated annual amounts you will pay for child and/or elder care.

Annual Child Care Expenses

Day care center $_____
In-home care $_____
Nursery and preschool $_____
After-school care $_____
Au pair services $_____

Summer day camp $_____
Annual Elder Care Services $_____
Day care center $_____
In-home care $_____

Total Estimated Annual Dependent Care Contribution

Total $_____

increase your tax savings

FSA Enrollment Form

Enroll in the Flexible Spending Account plans below.

You could save 30% or more on out-of-pocket health care and/or dependent care expenses.

Employee Information (Please print clearly)

Last Name	First Name	Middle Initial	Social Security Number

Email Address	Date of Birth	Contact Number

Street (include apartment number)		

City	State	ZIP Code (+4 if available)

Health Care FSA

☐ ***I elect to participate*** protect $_____ annually from taxes
Use the worksheet to determine the amount necessary to cover your annual expenses.

☐ ***I elect not to participate***

Dependent Care FSA

☐ ***I elect to participate*** protect $_____ annually from taxes
Use the worksheet to determine the amount necessary to cover your annual expenses.
Your FSA enrollment materials fully describe the qualification criteria for dependent care expenses.

☐ ***I elect not to participate***

To obtain a confirmation statement and claim form, go to www.ceridian-benefits.com and log in to your account.
For first time users, your password/pin is the last four numbers of your SSN reversed.

Authorization

I understand that by signing and submitting this form, I authorize the adjustment of my annual taxable salary based on my elections above, with the "tax protected" funds being transferred into my Flexible Spending Account. My election cannot be changed during the plan year, unless I experience an eligible change in status. I further understand that this form must be signed and dated prior to my plan effective date to be eligible to participate in this plan year. Any unused amounts remaining in my account at the end of the plan year will be forfeited. However, I will have a specified period of time (indicated in the FSA enrollment materials) after the end of the plan year or date of my termination to submit receipts for reimbursement for services received during the plan year or employment period.

Employee Signature X _____ Date _____

TO BE COMPLETED BY EMPLOYER

Company Name	Division	Effective Date
Milwaukee County		

Client ID	Plan Year		Pay code
1083	FROM:	TO:	

Direct Deposit Authorization

Flexible Spending Account

PLEASE ATTACH A VOID CHECK HERE
DEPOSIT SLIPS NOT ACCEPTED

INSTRUCTIONS (Please print all information legibly).

1. Attach a void check if you designate a checking account. **Do not submit a deposit slip**. If you designate a savings account attach a completed Savings Account Direct Deposit Form from your financial institution.
2. Please sign and date the form. Omission of signature will delay processing.
3. Mail completed form to the address indicated at the bottom of the page.
4. Notify Ceridian immediately of any account changes or account closings.

Direct Deposit authorization requires that all account and bank routing numbers be verified for accuracy before any funds are transferred. Eligible claims submitted during the 10-day verification period will be reimbursed with a check. After the verification period, reimbursements will be posted to your bank account two to four days after the scheduled reimbursement date. You will receive a Reimbursement Statement through the mail. Always verify your statement to make sure it is not a negotiable check.

EMPLOYEE INFORMATION

First Name_____ Last Name_____

Social Security Number _____-_____-_____ Daytime Telephone (_____) _____

Employer Name **Milwaukee County** Client Code **1083**

BANK INFORMATION

Check only one:

- ☐ Set up Direct Deposit for:
  - ☐ Checking (attach void check above)
  - ☐ Savings (attach a Savings Account Direct Deposit Form from your financial institution)
- ☐ Change Account Information
- ☐ Cancel Direct Deposit

Full Bank Name _____ Telephone (_____) _____

Bank Routing Number (9-digit number on lower left of check) |___|___|___|___|___|___|___|___|___|

Bank Account Number (to 17-digits) |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

IMPORTANT

- The designated account must be in your name.
- Processing of your Direct Deposit information will be delayed if you do not include both the bank account number and the bank routing number. Call your bank if you are unsure of your bank account information.

AUTHORIZATION

I hereby authorize Ceridian to initiate credit entries for depositing my Flexible Spending Account (FSA) reimbursements into my account designated above and, if necessary, make corrections for any entries made to my account in error. This authority is to remain in full force and effect until Ceridian has received written notification from me of its termination in such time and in such manner as to afford Ceridian a reasonable opportunity to act on it.

Employee Signature_____ Date_____

Mail to: Ceridian • P.O. Box 534200 • St. Petersburg, Florida 33747-4200